DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8653 **Revised**	Related Change Request (CR) #: CR 8653
Related CR Release Date: March11, 2014	Effective Date: April 1, 2014
Related CR Transmittal #: R2903CP	Implementation Date: April 7, 2014

April 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was revised on March 11, 2014, to reflect a revised Change Request (CR). The revised CR replaced the words "Program Memorandum" located in Chapter 17, Section 90.2.1 with "Recurring Update Notification." The CR release date, transmittal number and link to the CR also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Part A Medicare Administrative Contractors (A MACs) and Home Health and Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8653 which describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 2014 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 8653. Be sure your billing staff are aware of these changes.

Background

Change Request (CR) 8653 describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 2014 I/OCE and OPPS Pricer will reflect the HCPCS, APC, HCPCS Modifier, Status Indicators (SIs), and Revenue Code additions, changes, and deletions identified CR 8653.

The April 2014 revisions to I/OCE data files, instructions, and specifications are provided in the April 2014 I/OCE CR8658.Upon release of CR8658, a related MLN Matters® article can be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters Articles/Downloads/MM8658.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

The key changes in the April 2014 update to the hospital OPPS are summarized in the following sections.

Changes to Device Edits for April 2014

The most current list of device edits can be found under "Device and Procedure Edits" at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/** on the Centers for Medicare & Medicaid Services (CMS) website. Failure to pass these edits will result in claims being returned to the provider.

No Cost/ Full Credit and Partial Credit Devices

Effective January 1, 2014, CMS will no longer recognize the modifier FB (Item provided without cost to provider, supplier, or practitioner, or credit received for replaced device) or the modifier FC (Partial credit received for replaced device), which are used to identify a device that is furnished without cost or with a full or partial credit. Also effective January 1, 2014, for claims with APCs that require implantable devices and have significant device offsets (greater than 40 percent), the amount of the device credit will be specified in the amount portion for value code “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) and will be deducted from the APC payment from the applicable procedure. The OPPS payment deduction for the applicable APCs referenced above will be limited to the total amount of the device offset when the FD value code appears on a claim.

The offset amounts for the above referenced APCs, along with the offsets for other APCs, are available under the 'Annual Policy Files' link on the left column at **http://www.cms.gov/HospitalOutpatientPPS/** on the CMS OPPS website.

CMS is updating the "Medicare Claims Processing Manual" (Chapter 4, Sections 61.3.1 through 61.3.4) and adding Sections 61.3.5 through 61.3.6 to Chapter 4 of that manual to reflect these changes to the reporting guidelines for no cost/ full credit and partial credit devices, and these revised and added sections are included as an attachment to CR 8653. Those added sections are included in the following sections.

61.3.5 - Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital or When the Hospital Receives a Full or Partial Credit for the Replacement Device Beginning January 1, 2014

Effective January 1, 2014, when a hospital furnishes a new replacement device received without cost or with a credit of 50 percent or more of the cost of a new replacement from a manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Replaced Medical Device). Also effective January 1, 2014, hospitals must report one of the following condition codes when the value code "FD" is present on the claim:

- **49 Product Replacement within Product Lifecycle**—Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
- **50 Product Replacement for Known Recall of a Product**—Manufacturer or FDA has identified the product for recall and therefore replacement.

61.3.6 - Medicare Payment Adjustment Beginning January 1, 2014

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-14, Implementation: 01-05-09)

Effective January 1, 2014, Medicare payment is reduced by the amount of the device credit for specified procedure codes reported with value code "FD." The payment deduction is limited to the full device offset when the FD value code appears on a claim. Payment is only reduced for procedure codes that map to the APCs on the list of APCs subject to the adjustment that are reported with value code "FD" and that are present on claims with specified device HCPCS codes.

The OPPS Pricer deducts the lesser of the device credit or the full unadjusted device offset amount from the Medicare payment for a procedure code in an APC subject to the adjustment when billed with value code "FD" on the claim. This deduction is made from the Medicare payment after the multiple procedure discounting and terminated procedure discounting factors are applied, units of service are accounted for, and after the APC payment has been wage adjusted.

When two or more procedures assigned to APCs subject to the adjustment are reported with value code "FD," the OPPS Pricer will apportion the device credit to the applicable line on

the claim for each procedure assigned to an APC subject to the adjustment. When value code "FD" is reported on a claim where multiple APCs would be subject to the adjustment, the OPPS Pricer apportions the device credit to each of those lines. The percentage of the device credit apportioned to each applicable line is based on the percentage that the unadjusted payment of each applicable line represents, relative to the total unadjusted payment for all applicable lines.

NOTE: The tables of APCs and devices to which the offset reductions apply, and the full and partial offset amounts, are available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html** on the CMS website.

New Services

New services listed in Table 1 below, are assigned for payment under the OPPS, effective April 1, 2014.

Table 1 – New Services Payable under OPPS Effective April 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9739	4/01/2014	T	0162	Cystoscopy prostatic imp 1-3	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	$2,007.32	$401.47
C9740	4/01/2014	T	1564	Cysto impl 4 or more	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	$4,750.00	$950.00

Extended Assessment and Management (EAM) Composite APC (8009)

Effective January 1, 2014, CMS will provide payment for all qualifying extended assessment and management encounters through newly created composite APC 8009 (Extended Assessment and Management (EAM) Composite). Any clinic visit, Level 4 or Level 5 Type A Emergency Department (ED) visit, or Level 5 Type B ED visit furnished by a hospital in conjunction with observation services of eight or more hours will qualify for payment through APC 8009. Effective January 1, 2014, CMS will no longer provide payment for extended assessment and management encounters through APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level I Extended Assessment and Management Composite).

CMS is updating the "Medicare Claims Processing Manual" (Pub. 100-04, Chapter 4, Sections 10.2.1 and 290.5) to reflect these changes to the EAM Composite APC reporting guidelines. These updated sections are included as an attachment to CR 8653.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2014

In the Calendar Year (CY) 2014 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. You can review the CY 2014 OPPS/ASC final rule at **http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf** on the Internet. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2014 release of the OPPS Pricer.

The updated payment rates, effective April 1, 2014 will be included in the April 2014 update of the OPPS Addendum A and Addendum B, which will be posted at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html** on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2014

Two drugs and biologicals have been granted OPPS pass-through status effective April 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2014

HCPCS Code	Long Descriptor	Short Descriptor	APC	Status Indicator
C9021*	Injection, obinutuzumab, 10 mg	Injection, obinutuzumab	1476	G
Q4121	Theraskin, per square centimeter	Theraskin	1479	G

Note: The HCPCS code identified with an "*" indicates that this is a new code effective April 1, 2014.

c. Revised Status Indicator for HCPCS Codes A9545, J1446, J7178, and Q0181

Effective April 1, 2014, the status indicator for HCPCS code A9545 (Iodine I-131 tositumomab, therapeutic, per treatment dose) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective January 1, 2014, the status indicator for HCPCS code J1446 (Injection, TBO-Filgrastim, 5 micrograms) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment).

Effective January 1, 2014, the status indicator for HCPCS code J7178 (Injection, human fibrinogen concentrate, 1 mg) will change from SI=N (Paid under OPPS; payment is

packaged into payment for other services. Therefore, there is no separate APC payment.) to SI=K (Paid under OPPS; separate APC payment).

Effective January 1, 2014, the status indicator for HCPCS code Q0181 (Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.).

These codes are listed in Table 3 below, along with the effective date for the revised status indicator.

Table 3 – Drugs and Biologicals with Revised Status Indicators

HCPCS Code	Long Descriptor	APC	Status Indicator	Effective Date
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose		E	4/1/2014
J1446	Injection, TBO-Filgrastim, 5 micrograms	1477	K	1/1/2014
J7178	Injection, human fibrinogen concentrate, 1 mg	1478	K	1/1/2014
Q0181	Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as		N	1/1/2014

d. Updated Payment Rate for Q4127 Effective April 1, 2013 through June 30, 2013

The payment rate for Q4127 was incorrect in the April 2013 OPPS Pricer. The corrected payment rate is listed in Table 4 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on April 1, 2013 through June 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 4 – Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013 through June 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4127	G	1449	Talymed	$13.78	$2.76

e. Updated Payment Rate for Q4127 Effective July 1, 2013 through September 30, 2013

The payment rate for Q4127 was incorrect in the July 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on July 1, 2013, through September 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 5 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2013 through September 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4127	G	1449	Talymed	$13.78	$2.76

f. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 1, 2013

The payment rates for three HCPCS codes were incorrect in the October 2013 OPPS Pricer. The corrected payment rates are listed in Table 6 below, and they have been installed in the April 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 31, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
A9600	K	0701	Sr89 strontium	$1,196.47	$239.29
J2323	K	9126	Natalizumab injection	$12.99	$2.60
Q4127	G	1449	Talymed	$13.78	$2.76

g. Reassignment of Skin Substitute Products that are New for CY 2014 from the Low Cost Group to the High Cost Group

In the CY 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. You can review the CY 2014 OPPS/ASC final rule at **http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf** on the Internet. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using Current Procedural Terminology (CPT) codes 15271-15278) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278). Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the CY 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013

payment rate that was at or below $32 per square centimeter are paid through the low cost group for CY 2014. As a reminder, for CY 2015, CMS will follow the usual policy with regard to the specific quarterly ASP data sets used for proposed and final rule-making in that CMS will use April 2014 ASP data to establish the proposed rule low/high cost threshold, and CMS will use July 2014 ASP data to establish the final low/high cost threshold for CY 2015.

CMS also finalized a policy that for any new skin substitute products approved for payment during CY 2014, CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There were nine new skin substitute products that were effective January 1, 2014, and that were assigned to the low cost payment group because pricing information was not available for these products at the time of the January 2014 update. There is now pricing information available for three of these nine products. Table 7 below, shows the 3 new products and their low/high cost status based on the comparison of the price per square centimeter for each product to the $32 square centimeter threshold for CY 2014.

Table 7– Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014

HCPCS Code	Long Descriptor	Status Indicator	Low/High Cost Status
Q4143	Repriza, Per Square Centimeter	N	Low
Q4147	Architect Extracellular Matrix, Per Square Centimeter	N	High
Q4148	Neox 1k, Per Square Centimeter	N	High

h. Billing Guidance for the Topical Application of Mitomycin During or Following Ophthalmic Surgery

Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J3490 (unclassified drugs) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name Mitosol®. Any other topical mitomycin should be reported with J3490. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

New HCPCS Code Effective April 1, 2014

One new HCPCS code has been created for reporting services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration. This code is listed in Table 8 below, and it is effective for services furnished on or after April 1, 2014.

Table 8– New HCPCS Codes Effective April 1, 2014

HCPCS Code	Long Descriptor	Short Descriptor	Status Indicator Effective 4/1/14
Q2052	Services, supplies and accessories used in the home under the Medicare intravenous immune globulin (ivig) demonstration	Ivig demo, services/supplies	N

Changes to OPPS Pricer Logic

Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied to the applicable procedure line based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code "FD," which reduces the post wage-adjusted APC line payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs, along with the offsets for other APCs, is available under the 'Annual Policy Files' link on the left column at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html** on the CMS OPPS website.

Coverage Determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR 8653, issued to your MAC regarding these changes is available athttp://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2903CP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.